

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 010937	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/31/2013
NAME OF PROVIDER OR SUPPLIER ASSISTED LIVING AT HARTSFIELD VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 10002 COLUMBIA AVE MUNSTER, IN 46321		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	<p>INITIAL COMMENTS</p> <p>This visit was for a State Residential Licensure Survey.</p> <p>Survey dates: December 26 and 27, 2013</p> <p>Facility number: 10937 Provider number: 10937 AIM number: N/A</p> <p>Survey team: Cynthia Stramel, RN, TC Yolanda Love, RN</p> <p>Census bed type: 68 Total: 68</p> <p>Census payor type: Other: 68 Total: 68</p> <p>Sample: 9</p> <p>Assisted Living at Hartsfield Village was found to be in compliance with 410 IAC 16.2 in regard to the State Residential Licensure Survey.</p> <p>Quality review completed on December 29, 2013, by Janelyn Kulik, RN.</p>	R 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE